Neutral Citation Number: [2013] EWHC 3645 (Fam)

Case No: IL13C00118

**IN THE HIGH COURT OF JUSTICE**
**FAMILY DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/11/2013

**Before** :

**MRS JUSTICE PAUFFLEY**

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**Re T and M (Children: Fact Finding: Physical Injury)**

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**Helen Soffa** for the Applicant local authority
**Anthony Kirk QC and Markanza Cudby** for the mother
**Paul Storey QC and Jonathan Wilkinson** for the father
**Khatun Sapnara** for the children's guardian

Hearing dates: 4th – 15th November 2013

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# Judgment

The judgment is being distributed on the strict understanding that in any report no person other than the advocates or the solicitors instructing them (and other persons identified by name in the judgment itself) may be identified by name or location and that in particular the anonymity of the children and the adult members of their family must be strictly preserved.

**Mrs Justice Pauffley :**

1. Just before 1 o'clock in the afternoon of 5th February this year, a call was made to the emergency services by the father of a 13 month old girl who was struggling to breathe. When a London Ambulance Service paramedic arrived just 8 minutes after the call was made, he found no signs of life. Considerable resuscitation efforts were made both by the paramedic, his Ambulance Service colleagues and latterly a large medical team at the hospital to which the child was conveyed. Sadly, very sadly it was impossible to revive her. At 13.47 on 5th February death was confirmed.

2. This hearing has been to investigate, so far as possible, the cause of death and also – arising out of post mortem examination – the origins of no fewer than 70 fractures; fractures which occurred within two timeframes – two to four weeks and two to fours

days before the child's death.

3. One of the central questions for investigation had been as to whether the fractures were the result of inflicted injury or whether instead a naturally occurring medical or genetic condition may have been causative or rendered the child's bones more susceptible to injury. After the oral evidence of an osteoarticular pathologist, at the end of the first week of the hearing, most if not all of the medical issues had been eliminated and decisively so. Sensibly, decisions were taken not to require other medical experts, two radiologists and a clinical scientist with a specialist interest in osteogenesis imperfecta, to attend for oral evidence.

4. The remaining issue of vital significance to the four surviving children of the family is the identity of the perpetrator of the injuries. It would always be necessary to seek to discover, if possible, the individual responsible for causing the injuries because of the importance of so doing for future planning. If I can be satisfied – to the requisite standard on the basis of cogent evidence – that responsibility lies with one individual and that the other should be excluded, then I must say so.

*Essential background*

5. This is the essential background. The four surviving children, two boys and two girls, were born in Somalia. The boys are 12 and 9 ½ years old; the girls are 5 and 3 ¾. Their parents are KT and OS. In May 2011, the mother came to this country as a refugee leaving the four children with their father in Somalia. He looked after them, with the assistance of his own and the mother's sister, first in Somalia and then Uganda.

6. The mother gave birth to A on 1st January 2012 in London. By that time, she had been given Home Office permission to remain in this country. In August 2012, A was taken to St Mary's Hospital Paddington as the result of breathing difficulties and a temperature. It was thought she had mild asthma.

7. On 5th December 2012, the father and the four older children of the family arrived at Heathrow. The family was reunited. Two days later, on 7th December, they all moved in to their home in Greenwich.

8. On 5th February, at a time when the mother was away from the family home, the father made a call to the emergency services. A was found to be pale and unresponsive. Her pupils were non reactive. There was no heart rate or respiratory effort.

9. There was milk around the child's mouth; there was an empty bottle nearby. Once in A&E, milk was found in the trachea. There were no marks of any significance found on A's body. It was only when post mortem examination, preceded by a skeletal survey, was performed that the bony injuries were discovered – multiple fractures of the ribs, the scapula (shoulder blade), and the long bones in both upper and lower limbs. All of the

fractures showed early or more advanced levels of healing and thus could not have been direct cause of death.

10. On 7th February 2013, the four surviving children were taken into police protection and placed with foster parents.

*Medical issues*

11. When the hearing began, the medical issues appeared widespread. The most obvious were as follows. Was there, could there be, a link between the many fractures found at post mortem and the cause of death? Did osteopenia, as provisionally detected by a group of consultant radiologists at Great Ormond Street Hospitals, mean that A's bones were more susceptible to fracture than would ordinarily be the case? Was there Vitamin C or Vitamin D deficiency which may have explained her bony injuries? Did A suffer from a form of Osteogenesis Imperfecta? Was there evidence of any collagen reduction in the child's bones? What was the timeframe for injury and, if more than one episode, was it possible to be precise as to when the fractures occurred? What was the child's likely presentation in the aftermath of whatever happened to cause her fractures; and, if inflicted, would the person who was not responsible have been expected to notice that something was wrong?

12. After the evidence had been completed, and on the morning of submissions, a letter was received from a hospital in Somalia stating that two family members, the father's siblings, had been clinically diagnosed with osteopetrosis or 'marble disease' giving rise to increased bone density, anaemia and bone fractures. Accordingly, it was necessary to direct a further question to the consultant osteoarticular pathologist so as to ascertain whether A's bones showed signs of that condition.

*Burden and standard of proof: legal guidelines*

13. It is for the local authority to prove its case – in this instance that A suffered non accidental injuries. Neither parent has to prove anything. I remind myself that the test to be applied to the identification of perpetrators as to any other factual issue in the case is the balance of probabilities, nothing more and nothing less.

14. It is also established that there is no obligation upon a judge to decide who has harmed a child if he cannot. If he can, the judge should identify the probable perpetrator but he should not strain to do so.

15. Where a judge is considering an 'uncertain perpetrator' finding, he must be satisfied in relation to each potential perpetrator that there is a 'real possibility' on the evidence that that individual inflicted the injuries. But a real possibility that something has happened in the past is not enough to predict that it will happen in the future. A finding of a real possibility that one or other parent harmed a child does not establish that he or she did. Only a finding that he or she has harmed the child, as the case may be, can be sufficient to found a prediction that because it has happened in the past the same is likely to happen

in the future.

16. When considering issues of credibility, I remind myself that there are many reasons why a person in proceedings such as these might lie. They may do so for a whole host of motives. Not necessarily because they are culpable but, for example, to protect someone else; or out of shame; or from a wish to conceal disgraceful behaviour from their family or the community in which they live. The mere fact that a potential perpetrator lies is not in itself evidence of guilt. Almost never in a situation of this kind, would it be sufficient evidence of blameworthiness to establish that someone had lied.

17. I also remind myself – in connection with the medical evidence – that (i) the cause of an injury or an episode that cannot be explained scientifically remains equivocal; (ii) particular caution is necessary in any case where the medical experts disagree, one opinion declining to exclude a reasonable possibility of natural cause; (iii) I must always be on guard against the over-dogmatic expert, the expert whose reputation or self respect is at stake, or the expert who has developed a scientific prejudice; (iv) I must never forget that today's medical certainty may be discarded by the next generation of experts or that scientific research will throw light into corners which are at present dark.

*Uncontroversial medical matters*

18. In very large measure, the medical questions have resolved. This part of the judgment comprises the matters about which, on the expert evidence, there is no dispute.

*(i) Cause of death*

19. The immediate cause of A's death would appear to have been inhalation of stomach content. The origin of that and any relationship it might have had to her physical injuries – the extensive fractures – remain speculative. As Professor Risdon, consultant forensic paediatric pathologist, said in evidence – he had "*not found any link between the injuries and the cause of death*." The presence of numerous food particles in the small airways is significant in suggesting that aspiration of stomach content was the immediate cause of death.

20. Dr Essex, consultant developmental paediatrician, said in evidence that for A "coughing would be difficult because of the effect of the rib fractures." She could have had, he said, problems in eating and drinking. However, he had no view or opinion as to the cause of death beyond those expressed by Professor Risdon.

21. I should add that nothing said by the father during the course of the call to emergency services or in his evidence at this hearing sheds any further light on the cause of A's death. Consistent with his written evidence, all the father was able to contribute about events that morning was that A had been asleep upstairs. He had heard her breathing, loud breathing. The father went upstairs and brought her down. She was sweating and breathing in and out. He had put her on top of him and her "situation was not good". He

had made his phone call to emergency services "with little English."

22. I end this part of the judgment as I began with Professor Risdon's opinion which no one has sought to challenge.

*(ii) Timeframe for injury*

23. The timeframe for injury and the precision which has been possible in this case, derives from Professor Freemont's evidence. Dr Calder was at pains to stress how he would defer to the histopathogical evidence; and when Professor Freemont, Professor of Osteoarticular Pathology, described the processes involved in conducting his dating assessment, it was easy to understand why that should be.

24. He explained how radiologists are looking at the shadow of calcium which the X rays will not pass through. The rate at which bones heal varies according to the age of the child and nutrition and therefore the rate of calcification is variable. The radiologists' "window" tends to be wider because they cannot look at the cells through the microscope. A histopathologist will recognise the 'milestones' reached in the two to four day period as well as those which apply to the two to four week period. He, Professor Freemont, is able to see the start of new healing processes which can only be viewed through a microscope.

25. In relation to the newer injuries, there are – he explained – 'milestones' at 6, 12, 24 and 48 hours. It is usually possible to distinguish between injuries occurring between 2 and 24 hours; and it is "*always possible to differentiate between 2 and 48 hours.*" Thus he is able to say there was "*definitely*" injury that "*preceded CPR by 2 days*."

26. As for the older fractures, Professor Freemont said he was able to "*be really quite accurate*" that they fell within the two to four week window. The probability of those injuries falling outside that timeframe was only 5%; so there is a 95% probability that they are within 2 to 4 weeks. Looking at the histology, he said there may have been more than one event within that time period; but he is "*absolutely certain there were two sets of fracturing events*," 2 – 4 days and 2 – 4 weeks.

*(iii) Mechanism for injury*

27. As for the mechanism for injury, again there is no dissent. The fractures at the costochondral junctions of the ribs and long bone metaphyseal fractures are well–recognised sites for non accidental bony injuries. Rib fractures result from forceful circumferential squeezing as when an adult seizes the child's torso and exerts very considerable pressure around the rib cage. Metaphyseal fractures are the result of severe twisting and pulling, tortional forces applied to the limb.

28. The scapula, said Professor Freemont, is a large flat bone which can dissipate energy easily. The first rib, likewise, is a flat bone tucked behind the collar bone. To fracture

either of those bones would require high energy trauma. He thought the rib injury was caused as part of part of the same event as the injury to the other ribs; and it was reasonable to judge it as some "*forceful event*".

*(iv) Presentation in the aftermath of injury*

29. A's likely presentation in the aftermath of injury is the last of the medically uncontroversial matters. Amongst the experts who gave oral evidence there was complete consensus of opinion.

30. Professor Risdon said he would imagine that the child would have been in a "*fairly parlous state because of the number of her injuries*." She would have had difficulty in moving and breathing (but he would not make a link between the injuries and cause of death because there was not enough evidence to support that.)

31. Dr Calder said that shortly after the ribs were fractured, A would have been in considerable pain and her ability to breathe may have been affected. He would defer to a paediatrician.

32. Dr Essex said that in general terms there would have been acute pain at the time of the fractures and for quite a number of minutes thereafter – 10, 20 or 30. The child would "*cry very severely, more than whingeing*" and then settle. But when the affected part of the body was touched or moved, the crying or distress would flare up again; and that would last on his "*guesstimate*" for 2, 3 or 4 days, getting less all the time. The child would have taken shallow, rapid breaths to reduce the irritation caused by her fractured ribs. Eating and drinking could have been affected. She would have been reluctant to move her arm or shoulder as the result of the fractured scapula. Her ability to crawl as well as to pull herself up to stand would have been affected as well. Overall, said Dr Essex, A would have been "*very distressed and in a lot of pain. She would have kept herself still. She would not have been happy and she would not have been lively.*"

33. Professor Freemont commented that during the first timeframe for injury, A sustained more than 40 different fractures; he believed she would have been immobilised.

*(v) The condition of A's bones*

34. The issues surrounding the condition of A's bones, whether there might have been metabolic bone disease, osteopenia, osteogenesis imperfecta, Vitamin D or C deficiency, collagen deficiency and so on were answered, and definitively so, during Professor Freemont's evidence. In his written report he had said he saw no evidence of metabolic bone diseases, no evidence of osteogenesis imperfecta or osteoporosis. There was some abnormality in the ribs but that was not due to Vitamin D deficiency, rather the age and nature of the fractures.

35. In his oral evidence, Professor Freemont said "*the bones (he) saw were completely*

*normal.*"

36. In relation to osteopenia, Professor Freemont said he believed the radiologists were "*in a difficult position to make a fine judgment about the bone. Down a microscope it is much easier to see how much bone tissue is present*." He said he "*found no evidence of osteopenia histologically*." I pause to mention that Dr Johnson, consultant radiologist, saw no evidence of osteopenia either. Dr Calder, also a consultant radiologist, said in evidence that in cases where osteopenia is a factor, one did not tend to find this number and pattern of fractures. His view as to the most likely cause of the osteopenia seen by him and his colleagues was "*immobilisation of the child as the result of the fractures which can happen quite rapidly*." Professor Risdon said much the same, commenting that the detection of osteopenia is a "*pretty subjective business*"; and that if "*a child is immobilised and not using her limbs – as when in plaster – then there may well be some loss of calcium from that alone*."

37. In relation to Vitamin C deficiency, Professor Freemont said that if present it would cause a disruption of the amount of bone close to where it is growing, that is the growth plate. There would be less bone and it would be thinner. A Vitamin C deficiency could be detected on most bones; the ribs would be "*perfectly adequate for that purpose*." He saw no evidence of anything other than normal bone.

38. Professor Freemont's evidence about the potential for Vitamin D deficiency, osteogenesis imperfecta and collagen reduction was in similar vein. Although he accepted that A's Vitamin D levels could have been at the lower end of normal, what he saw under the microscope was "*not below the lower end of normal in the amount and condition of bone*." He would not expect to see anything in a child "*with lowish Vitamin D levels because that would not have affected the amount of bone tissue.*"

39. Osteogenesis imperfecta, explained Professor Freemont, causes imperfect bone formation and he would have expected to see "*other decreases in the skeleton*." In general terms, he did not see any reduction in the amount of bone.

40. As for any decrease in the amount of collagen in the bone, Professor Freemont observed that it would only be seen if it had resulted in a loss of bone. If collagen were "*significantly reduced to the point where bones more easily fractured*" then he would have noticed it; and he did not.

41. In response to the letter from the Somali hospital suggestive of inherited osteopetrosis, Professor Freemont emailed very early on the morning of Sunday 17th November. He said this – "*In terms of the histological features of osteopetrosis, these include the lack of osteoclasts, increase in cartilage in bone trabeculae and islands of bone within the marrow. None of these features was present in A's bone. There is, therefore, no histological evidence of osteopetrosis in this child.*"

*Discussion and decisions – cause of the fractures*

42. With all of those matters in mind, I turn to the various issues for decision. I begin with A's injuries and my findings about them.

43. Whilst the parents' legal teams acknowledge there is no support within the medical evidence for any naturally arising condition so as to account for A's fractures, Mr Storey QC nonetheless – and perfectly properly – invites me to consider whether there may have been an unknown cause.

44. I reject that suggestion and for the reason that the medical evidence from all sources – pathology, histology, paediatrics and radiology – impels me so to do. Seldom in a case involving fractures is it possible to have scientific analysis of the kind provided by Professor Freemont. Here there is a cohesive swathe of medical evidence which points irrefutably to inflicted trauma as the cause of injury.

45. In his oral evidence, Professor Freemont supplied a degree of analysis arising out of his microscopic assessment of A's bone tissue which was both well-explained, for my purposes, and utterly compelling as to its scientific origins. He is an expert upon whose evidence it is entirely safe to rely. He enables me to say, with complete conviction, that A's bones were completely normal; that she did not have any metabolic bone disease; and that her bones were not affected by vitamin deficiency or collagen reduction.

46. The overwhelming probability is that A's fractures were the result of severe inflicted trauma on at least two occasions – the most recent between 2 and 4 days of her death, the other between 2 and 4 weeks prior to death.

*Seeking to identify the perpetrator*

47. I turn now to the issue of which parent, if it was only one, was responsible for A's injuries. This is not a case where others are proposed as potential perpetrators. Only the mother and father looked after A during the two months preceding her death. Both parents gave evidence over several hours during the second week of the hearing. In their final submissions, Mr Kirk QC and Mr Storey QC invited me to exculpate their respective clients, drawing together a number of matters which, so they argued, would entitle me to find the other parent was to blame.

*The father's case*

48. Mr Storey and Mr Wilkinson drew attention to the father's tragic background of having lost three children. A child of his first marriage and the eldest of his second both killed on the same day when the family lived in Somalia; and most recently, of course, A's death. From May 2011 until December 2012, the father looked after the four children in Somalia in the absence of their mother and, said Mr Storey, he "delivered" – the youngest at only 14 months old, was of a very similar age to A, when the mother departed for the UK.

49. When the father arrived in England, he was "delighted to be here," so it was argued. He and the children had arrived in a safe place; they were housed and fed; the older two children were provided with education. Money was coming in. The father was reunited with the mother and met A for the first time. He had, submits Mr Storey, much to be grateful for.

50. Considering the position of the mother, Mr Storey, wondered whether the arrival of the father and four older children had caused her difficulty, stress and / or additional responsibilities?

51. Mr Storey invites me to conduct an "honest, intellectual exercise" in seeking to identify the perpetrator and offers the following in support of his submission that the mother should be found responsible. There is not, he suggests, a shred of evidence that she has ever suffered violence at the father's hands. He drew attention to the "sheer amount of physical contact" which the mother had with A. The cultural norm, which applied here, was for the mother to deal with all of the female children's physical care needs. Her own evidence moreover supports the fact that it was the mother, rather than the father, who bathed A, wiped her clean, oiled her body twice a day and changed her nappy.

52. Mr Storey places considerable reliance upon events at the GP's surgery on 15th January this year saying that the mother has told "a pretty substantial lie" which could be a relevant consideration. In addition, Mr Storey points to the evidence which is that the father knew about the intended consultation for a painful shoulder and did not seek to prevent it from occurring.

53. In relation to the potential for a finding against the father of 'failure to protect,' Mr Storey points to cultural differences and the lesser expected role for a father. He suggested that the incident which resulted in the appointment with the GP on 15th January might have represented 'an acute window' when A was demonstrating difficulties with one of her arms. Save for that period, when as the mother said in cross examination, A was "crying and screaming," there is, suggests Mr Storey, no other evidence of any pain reaction such as the child whimpering throughout the night. Thus, it is suggested on the father's behalf that he should be exonerated as well in relation to failing to protect A from harm.

*Submissions on behalf of the mother*

54. On behalf of the mother, Mr Kirk QC and Ms Cudby invite me to find that she should attract admiration, courage and fortitude for leading the family out of war-torn Somalia. By coming here as she did, in May 2011 pregnant with her sixth child, it is said that the mother should elicit sympathy – having left her husband and four children behind, without any idea as to when she might see them again. It was submitted that the mother deserved credit for all of the various steps she took to sort out the family's housing, state benefits, education for the boys, registration at the doctor's surgery and the organisation of crisis loans.

55. Why on earth, asked Mr Kirk rhetorically, given the family's exciting new start and all the mother had been through would she end up by seriously injuring her youngest child? A child who had brought her so much joy and happiness; and caused the four older children such delight when they first met her in December 2012. Those two months were, submitted Mr Kirk, a very happy time and there can be no proper basis for concluding that his client 'lost it' so as to cause A's fractures.

56. He also drew my attention to those parts of the evidence supplied to the police from which it would be fair to deduce that the mother was diligent in seeking out medical attention. In addition, she was viewed by relatives as providing excellent care for children, including her nephews and nieces. The father, suggested Mr Kirk, had no criticism of her for the way in which she looked after their children.

57. Unlike the father, submits Mr Kirk, the mother does accept that A sustained a substantial number of fractures. He invites my attention to a passage of his client's evidence during cross examination which, he invites me to say, in combination with everything else, would entitle me to find that the father and not the mother was the perpetrator.

58. In relation to the ABE interviews of the boys, Mr Kirk drew attention to a leading question asked of M in relation to A's leg injury; that the boys were, as the mother accepts, aware of A's sore arm; and that the younger, AR, was a less reliable historian than his older brother.

59. Finally, Mr Kirk suggested that the injuries were not caused by his client, who was away from the home for much of the time during the day, which means there is only one individual within the pool of perpetrators, namely the father; and he invites me so to find.

*Discussion and overall conclusion – identity of the perpetrator – failure to protect*

60. At the end of an extensive inquiry, assimilating a quantity of information about the family from all available sources, hearing the evidence from both sides and taking some time to consider my conclusions, I cannot exonerate either the father or the mother. I conclude that one or other, or perhaps even both of them, was responsible for A's terrible injuries. If it was one, rather than the other, then the parent who did not inflict injury was accountable for the most glaring failure to protect by omitting to seek out appropriate medical attention for a child who was obviously severely injured.

61. In some cases it is relatively straightforward to determine which of the two parents, in all probability, is the perpetrator. Sometimes the timeframe for the injuries has the effect of more or less decisively excluding one parent to the detriment of the other. Occasionally, there is a history of violence and failure to control temper, even within the court room setting, which may contribute to the exercise of identifying the individual who has caused the harm. On other occasions, the accounts given to the responsible agencies, shortly after the final incident, give rise to a sound starting point for ascribing responsibility to one person and exonerating the other. Very often, there is third party evidence about events surrounding the child's descent into ill health which assists in

deciding which individual was responsible. Sometimes it is material to analyse a number of accounts given to third parties so as to gain an understanding as to whether there was coherence and consistency which might assist. The possibilities are as many as they are variable.

62. In this instance I have searched, as I always would, for evidence of sufficient importance and validity so as to guide me towards a clear conclusion. Most unfortunately, my quest has been in vain. There is nothing sufficiently certain or solid so as to form the beginnings of a clear finding that the perpetrator was the father rather than the mother or vice versa.

63. So much remains unclear, as I shall go on to discuss. A wealth of information remains hidden from view for reasons known only to the parents. Lies have been told, of that I am quite sure; but where those lies lead it is impossible to say. They could arise from a desire to self protect. Equally well, they might result from a wish to shield the other parent or even the family's honour.

*Neither parent has been candid*

*(i) Responses to the boys' ABE interviews*

64. I turn now to the various matters which indicate, and strongly so, that neither parent has been truthful about matters of real importance. Each of them gave evidence about the boys' ABE interviews and, indeed, in response to the medical evidence which gives rise to an inevitable conclusion that the parents were lying.

65. Both boys, M (then 11 ½) and AR (rising 9), were interviewed by DC Watson of the Metropolitan Police's Major Incident Team on 20th February this year. I watched the whole of M's recorded interview and a substantial part of the discussion between the officer and AR. Both boys were fully co operative and, so far as possible in the circumstances, at their ease. Neither of them seemed frightened or worried. Their body language conveyed that they were relaxed. They had a perfect grasp of the difference between truth and lies. They concentrated well, were polite and, seemingly, did their best to answer the questions asked of them. Of the two, perhaps as the result of his age, M was a little more reserved. AR displayed a slightly playful side of his temperament when asked to recount something he had already said. AR humorously reminded the officer he had already given her that information which she had written down.

66. The salient information provided by M was that A had "*not been feeling very well … She fell ill twice. On one occasion she couldn't lift her arm and her arm was heavy, and she couldn't crawl and … you had to lift her to take her from one place to the other*." M was asked if she had seemed in pain. He said, "*yeah she was feeling pain when I tried to pick her up*."

67. Later, he was asked who he told about A's arm and leg – and Mr Kirk is quite correct as to an element of leading on the part of the officer in relation to 'the leg.' But this was M's

reply – "*On the first occasion she was feeling pain on her hand and then later on her leg.*" He agreed that first it was her arm and then her leg, adding, "*I couldn't even tell you which arm ... I couldn't even tell you which leg.*" Asked again who he had told, M replied, "*My mum ... When I was trying to pick her up, mum told me that her hand's aching, just be careful*." When the officer asked whether Mum knew already that A had a bad arm and leg, M responded – "*She knew that yes, but it was not at the same time, it was (I believe he said "one") and the other ... there were days in between."*

68. Still later in interview, M was asked whether A seemed happy. He replied, "*When she was healthy, very well, when she was ill she was not happy ... She stays like someone who is lame, like a lame person ... she stayed and look at, stare at, people*."

69. AR was asked to tell the officer about A. He said, "*She was fine apart from when she was not feeling very well and couldn't lift her, lift up her hand because she had a bad muscle and when she was about a month old the muscle ... move from her hand to her leg*." He added, "*On one month she was not feeling very well with her hand and the following month she was not feeling very well with ... her leg*."

70. In response to a question as to who he had told, AR said, "*She had a ... bad muscle in her hand and because of that she couldn't lift up her arm, even if you touch her (inaudible, possibly 'hair') back she is feeling pain... But later on the reason that we know that she has got a bad leg was that she couldn't crawl*." According to AR, "*The whole family knew that*." Later, and in reply to questions about the day on which A died, AR said, "*…mum and dad were not happy; they were not happy about A and I don't really know the reason why*."

71. So much then for the content and impression created by the boys at interview. There was no inkling, from the written evidence, as to the parents' reactions to what their sons had said. In their responses to the local authority's Scott Schedule, it was acknowledged that "these things were said" but in large measure the parents "denied knowledge of the matters asserted."

72. The DVDs of the interviews had been made available for all to watch. There was no application on behalf of either parent to question the boys. It was not until the father was cross examined by Ms Soffa that it became apparent he did not agree with much, if anything, of what the boys had said. He started by saying the boys had "*not told the truth*;" that in his culture, if a child is younger than 15, "*we don't take what they say*." Again and again when challenged to account for what the boys had said about A's condition, her problems in using her arm and leg, her pain and inability to crawl the father contended that "*she was the healthiest of the children.*" Indeed that phrase, with slight variations upon it, became something of a mantra. In all, he said A was "*the healthiest child in the house*" no less than seven times. According to him, there was "*nothing wrong with her and her health was 100%.*"

73. The mother's evidence as to the boys' ABE interviews was as follows – she believes that the way in which the boys were removed from home was terrifying; and children when they are "*terrified and shocked could say anything.*" They were, she said, "*new to this*

*country, removed from their parents and no one was speaking to them in their own language*." The mother stated that when she watched the video, she could see that M was "*shocked and terrified.*" She could, she said, "*feel the hardship. They may well have believed they were removed because of what had happened to A … Even an adult would be confused … young boys removed from home, they would say anything*."

74. I have fully in mind that the boys 'evidence' has not been challenged by cross examination. Had an application been made for M, in particular, to give evidence and if he had he been willing it may have succeeded. As it is, the only potential for assessment of what the boys have said has been to view the DVD and read the transcripts. But it cannot be anything other than highly material that, in so many respects, the boys corroborate one another as to how A was in the weeks leading up to her death.

75. The most striking thing of all, for me, is the extent to which the medical evidence as to A's likely presentation in the aftermath of injury coincides with the accounts given by the boys. I find it profoundly troubling that the parents are not prepared to acknowledge the reality which has to be that A was as impaired and immobilised as the doctors and their sons have described. Their united position as to A's state of health and denial of what the boys have said strongly supports a finding that they have both lied and are colluding with one another to suppress the truth.

*(ii) The GP appointment on 15th January*

76. The other stark example of a lack of candour arises out of events at the GP's surgery on 15th January. The mother maintains she took A to the doctor, together with her two older sisters, because she had a "*pain in her arm and a temperature.*" Because she had no English she "*indicated (her) daughter was sick*." She felt she was being asked which one and she "*pulled A from the pushchair and put her on (her) lap*." The mother described how she had "*raised the hand and indicated to the shoulder, by touching*". The doctor had checked her generally and said, 'Your daughter is well.' She was given drops for A's nose. The mother had taken A home, put Vaseline on her arm, massaged menthol oil into the shoulder and given her Calpol. Then, she said, "*A was well*."

77. In cross examination, the mother confirmed that she had demonstrated to the doctor by "*raising her hand up; (A) started crying… Yes she did show pain. The doctor was preoccupied by putting a thing (possibly a stethoscope) on her chest. She was preoccupied by writing.*" The mother agreed that she had taken almost all of A's clothes off for the purposes of the examination, jacket, jumper and underwear; and all would have required movement of the arm. The clothing was removed and then put on again in the doctor's presence and "*Yes, A had cried in pain when the clothes were taken off. She didn't stop crying from the beginning*." Asked as to whether the doctor had manipulated or moved A's arm, the mother said, "*Yes she did – pressed her hands again but not a lot of touch. She didn't handle her shoulder; she just checked her arm*."

78. The GP who saw the mother and A that day, Dr C, gave evidence. She frankly conceded that she had no memory of the consultation and relied exclusively upon her notes for the

evidence she was able to give. Usually appointments last for 10 minutes, this one was 7. The computerised record is in these terms – "*Upper respiratory tract infection NOS (? not otherwise specified) 3 days; mild temp no vomiting; drinking and pu (passing urine); o/e (on examination) temp 37; chest clear; throat nad (nothing abnormal detected); corzal (runny nose); for drops; advised when to seek help*."

79. Dr C speaks no Somali, agreed that communication could have been "*quite difficult*" but said that had there been communication difficulties she would have documented that in her notes and called 'Language Line.' Significantly, Dr C said that "*if the mother had told (her) or indicated there was a problem with the child's arm, (she) would have documented it*." Asked whether the mother had demonstrated there was difficulty with the child's arm, Dr C said, "*I would have written that in the notes. I would have done something about it. Nothing was documented. If she'd done either of those things – demonstrated on herself that A had a problem with raising her arm or pointed to A's arm indicating there was pain – then I would have examined the child, absolutely*."

80. Later Dr C agreed with Mr Storey that she does not see many children who cannot raise their arms above their shoulders; that an immobilised arm would amount to a child protection issue; and that it was "*inconceivable it would not have been noted.*" She agreed she would have referred the child to hospital had she been given a history of an immobilised arm.

81. Dr C was an impressive witness, clear about what she would have done in the situation which the mother had described in court. It is inconceivable, in my assessment, that the doctor would have failed to respond appropriately by conducting a full examination of A's shoulder and arm if the problem, in fact, had been drawn to her attention. Moreover, the written records arising out of the consultation would surely have contained reference to the difficulty.

82. I'm mindful, obviously, of the evidence, persuasively given, of Ms Y, the mother's friend who recalls the mother had "*definitely said A had a pain in her arm*" on 15th January. Ms Y was "*100% - she did say 'pain in the arm*.'" After the appointment, according to Ms Y, the mother had reported the GP as having said there was "*nothing wrong with A's arm*." After that, there was no mention of "*A being in pain – that was the end of it.*"

83. In similar vein, another of the mother's friends, Ms M, gave evidence of her knowledge that A "*feel pain in her shoulder,*" as reported to her by the mother. In her statement for the police, and as to this part Ms M confirmed its accuracy, she said the mother had asked her to accompany her to the surgery, that A could not raise her arm above her shoulder and every time the mother had tried to do so the baby would cry.

84. Mr Kirk submits that the mother was persistent and determined in making that appointment. Rhetorically, he asked why the mother would broadcast the fact of A's sore arm and then fail to follow through when they saw the doctor? He emphasised the language and communication difficulties and invites me to conclude that the mother did her best to describe there was a difficulty with A's arm and shoulder. Why, he asked,

would the mother go to the doctor if she had caused the fracture?

85. So what is to be made of this part of the case? It is, in fact, relatively straightforward, so it seems to me. The strong probability is that mother did indeed tell the father, Ms Y and Ms M that A had a problem with her shoulder. Indeed, I would speculate that she may have intended to tell the doctor as well. But when she was in the consultation room, I am as sure as I can be that she did not mention anything of the problem. Moreover, she lied in the witness box in seeking to convey all she did about the detail of the consultation. The records, it might be said, speak for themselves.

*Discussion between the parents about A's injuries*

86. I turn then to consider the parents' separation and what each has said to the other about A's injuries. They parted in September when, according to the father, they were "*facing hard times*," were stressed, they had lost a daughter and their other children had been taken from them. The mother, according to him, had said, "*It's when you come, the breaks have happened*." He said he had "*sweared to her – (he) knew nothing*." The father went on to say, "*No, I did not blame her for hurting A. I do not know who hurted her.*" He had asked the mother "*one time*" whether, when he was away, A had fallen from somewhere.

87. The father also said that the mother had asked him "*what happened to the girl, they are talking about fractures. She did not ask (him) if (he) had hurt her*." The father went on to explain that in his culture the children they give birth to have been given by God and they look after them, bring them up, so that they can look after their parents when they are older. A is, he said, "*part of his flesh*"; he would never think of harming her. Almost at the end of his evidence, he said he "*did not injure that girl and (does not) know who did*." He does not "*think the mother has injured her. (He) doesn't believe someone who has given birth to a child could have done something to her*."

88. The mother's evidence was that she had "*been led to the very sad conclusion that her husband may well have caused the injuries*." It is "*possible he knows*." She said she was "*not certain ... (they) were both responsible for the care of their daughter. (She) was busy, out most of the time, leaving her with him all of the time. ... Because (she) had not witnessed it, not seen it with (her) own eyes (she) cannot say it must be him.*" She went on, "*No I don't believe him when he says he's innocent… It's clear to me, the injuries were inflicted but I know it's not me. It can be nobody else but her father. It's a sin for me to say something has happened when I haven't seen it*."

89. The mother said that when she had received one of the medical reports she had shouted at the father. He said 'no', he did not. She said she could not face him and said, '*Go away'*!

90. As a starting point for the attribution of responsibility, the assertion that the mother has blamed the father but that he has not accused her strikes me as tenuous in the extreme. On its own, it simply could not be enough for the beginnings of a finding that one parent

was responsible and the other should be exonerated.

*Information which is lacking notwithstanding the separation*

91. In addition and strikingly, there is a marked lack of information provided by either parent as to so much of obvious potential relevance. I mention just the following. How they interacted on an emotional level with one another as a couple and as parents? What the state of their relationship was in the months after the reunification? How they coped with the competing demands of the five children? How they managed the stresses of settling in to life in this country – the cold, the language problems, the financial pressure, the educational needs of the older children? How they treated A?

92. A whole series of statements have been made by and on behalf of the parents from which, inferentially, I am invited to conclude that everything within the family was just fine. Self evidently, it was not. It was suggested that it had been a "*delight*" to be reunited as a family and that everyone was "*very happy*." The mother was, according to the father, "*a very good mother to all 5 children and a very good wife who was good*" for him. The mother confirmed that "*A was happy to be handled by her father. Only in the beginning when she was new to him did she show fear*." And again I remind myself of the father's oft repeated statement that A was "*the healthiest child of the family*." The mother was insistent that save for the arm problem of mid January, she "*did not know that A was feeling pain*."

93. At the end of this important hearing, I am unable to identify which of the parents, if it was only one, was responsible for so grievously harming A. All I can and do say is that it must have been one or other or both of them.

*Threshold criteria*

94. The threshold, for s.31 purposes, is definitively crossed in relation to all of the children. A, as I have found, suffered the most appalling degree of significant physical and emotional harm in that her multiple fractures were brutally inflicted by one or other or potentially both of her parents. The surviving children may be older and thus a little less vulnerable but they, too, would be at risk of substantial physical harm for so long as there is continuing uncertainty as to which parent, if it was only one, inflicted A's injuries. All of the children, as the result of my findings, are likely to suffer significant harm if a public law order is not made.

95. There continues to a serious risk of physical assault and if only one of the parents, in fact, inflicted A's injuries then the other most definitely failed to protect her from harm. I reject Mr Storey's suggestion that there was "an acute window" at around the time of 15th January when A was in distress and otherwise she was well. The medical evidence and information supplied to the police by the boys reveals a very different and intensely worrying situation. Both parents knew of A's pitiful condition but did nothing to alert the authorities.

96. Neither can be viewed as a protective parent. In addition, as the result of the way in which they have presented their evidence at this hearing, I am impelled to find that they have colluded with one another, notwithstanding an apparent separation, to suppress the truth.